MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

AIR AMBULANCE SERVICE LICENSE APPLICATION

FOR DOH OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

☐ INITIAL LICENSURE
☐ RELICENSURE
INSPECTOR ASSIGNED _____

AMBULANCE SERVICE LICENSE # ☐☐☐☐☐☐
DATE APPLICATION REC'D. ☐☐ ☐☐ ☐☐
DATE INSPECTOR ASSIGNED ☐☐ ☐☐ ☐☐
DATE OF FIRST INSPECTION ☐☐ ☐☐ ☐☐

DATE PASSED INSPECTION ☐☐ ☐☐ ☐☐
DATE LICENSED ☐☐ ☐☐ ☐☐
EXPIRATION DATE ☐☐ ☐☐ ☐☐

APPLICANT MUST COMPLETE INFORMATION BELOW ***TYPE OR PRINT***

TYPE OF LICENSE APPLIED FOR: ☐ ROTARY WING ☐ FIXED WING

1. TRADE NAME OF AIR AMBULANCE SERVICE (Name on aircraft) | NUMBER OF AIRCRAFT

LOCATION OF AMBULANCES *(STREET, ROUTE, CITY, STATE, ZIP)*

2. OPERATOR OF AIR AMBULANCE SERVICE

NAME OF PSD OR CORPORATION	NAME OF MANAGER	TELEPHONE NUMBER-BUSINESS ( )
BUSINESS ADDRESS *(STREET, ROUTE, ETC.)*		TELEPHONE NUMBER-EMERGENCY ( )
CITY / STATE / ZIP CODE	E-MAIL	FAX NUMBER ( )

3. MEDICAL DIRECTOR

NAME *(LAST, FIRST, MI)* ☐ M.D. ☐ D.O.		
ADDRESS *(STREET, ROUTE, ETC.)*		OFFICE TELEPHONE NUMBER ( )
CITY / STATE / ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an air ambulance service medical director and I agree to serve as medical director.

_____ _____
SIGNATURE OF AMBULANCE SERVICE MEDICAL DIRECTOR ***(USE INK OR INDELIBLE PENCIL)*** **DATE**

4. AIR AMBULANCE SERVICE LICENSEE

NAME OF POLITICAL SUBDIVISION OR CORPORATION	NAME OF CEO	TELEPHONE NUMBER-BUSINESS ( )
BUSINESS ADDRESS *(STREET, ROUTE, ETC.)*		TELEPHONE NUMBER-EMERGENCY ( )
CITY / STATE / ZIP CODE	E-MAIL	FAX NUMBER ( )

I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Air Ambulance Service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive EMS Act, Chapter 190, RSMo 1998.

I have attached all Air Ambulance Service licensure and related administrative licensure actions taken against this air ambulance service or owner by any state agency in any state.

_____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF AIR AMBULANCE SERVICE LICENSEE **DATE**

WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. Missouri statutes 575.060.

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102

MO 580-2176 (R9/01)
EMS-6